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ABSTRACT

A study of the choice of specialty by medical students suggests that Family Medicine depends on students whose choice predates medical school; the number of those interested diminishes significantly over the four years. Interviews suggest several characteristics of the medical school that mitigate against the choice of family medicine and steer the student toward specialty choices, particularly those linked with technological and topographical domains. The medical school, for several reasons, serves as an urbanizing force, representing conditions of density, heterogenity, division of labor, specialization, interdependence, and identifiable and defensible areas of control. While Family Medicine is perceived to be integrative and syncretic, the rewards offered to medical students emphasize the importance and rewards associated with subspecialization. The medical school is an environment in which students are steered away from Family Medicine by virtue of the practices and professional flavor associated with the educational experience of the student. Family Medicine, therefore, must be concerned not only with its image, but also with its conditions of practice. It must make hard decisions about its future and its ability to recruit. (Author/LBH)

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GOING THROUGH MEDICAL SCHOOL AND CONSIDERING THE CHOICE OF FAMILY MEDICINE: PRESCRIPTION OR ANTIDOTE?*

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A study of the choice of specialty by medical students suggests that Family Medicine depends on students whose choice predates medical school; the number of those interested diminishes significantly over the four years. Interviews suggest a number of characteristics of the medical school which mitigate against the choice of Family Medicine and steer the student towards specialty choices, particularly those linked with technological and topographical domains. The medical school, for several reasons, serves as an urbanizing force, i.e. representing conditions of density, heterogeneity, division of labor, specialization, interdependence, and identifiable and defensible areas of control. While Family Medicine is perceived to be integrative and syncretic, the rewards offered to medical students emphasize the importance and the rewards associated with subspecialization. The medical school is an environment in which students are steered away from Family Medicine by virtue of the practices and professional flavor associated with the educational experience of the student. Family Medicine, therefore, must be concerned not only with its image, but also with its conditions of practice. It must make hard decisions about its future and about its ability to recruit.

GOING THROUGH MEDICAL SCHOOL AND
CONSIDERING THE CHOICE OF FAMILY MEDICINE:
PRESCRIPTION OR ANTIDOTE?

Among recognized medical specialties, Family Medicine is a rather recent addition to the map of medical careers. Taking AMA approval as an index of institutionalization, Family Medicine is not yet ten years old. Its history and its current place within the profession of medicine is linked to a number of processes which have marked the emergence of this specialty simultaneously as a collective assertion of concern with primary and continuing care as well as an attempt by certain, status-deprived segments of medicine--largely from the struggling "general practice" sector--to claim new meaning, new vehicles, and new devices for upward mobility within the profession (Mauksch, 1974; Lewy, 1977). To some, Family Medicine represents a move towards a deliberate, professionally and scientifically based approach towards the integration of health and illness, with a holistic view of the patient and the patient as a member of the family. This is, in fact, a radical challenge to the individualistic, biopathological disease orientation of traditional medicine. To others, the emergence of Family Medicine has been primarily a reaffirmation of simple and basic humane interests in opposition to trends in a profession which has lowered emphasis on human contact, a price paid for gaining control over disease through technology and laboratory resources.

This new specialty clearly has its controversial components. The rhetoric of Family Medicine and its coverage by the mass media have served as a readily available symbol for a new version of personalized medicine. For some, this specialty is a move into a new direction of

sophisticated caring, while to others it symbolizes a return to old-fashioned virtues of human concern. Within the health field itself, Family Medicine has evoked controversy. Its very existence has visibly influenced certain specialties, such as Internal Medicine and Pediatrics; one consequence being the trend of developing programs in primary care within these disciplines. In some states, legislatures have voted funds specifically earmarked to support Family Medicine, frequently governed by the perception that fostering Family Medicine is tantamount to providing physicians for rural America and other heretofore medically underserved areas.

The range of images identified with Family Medicine range from appearing as the great hope of primary concerns in health care to being labeled a short-lived fluff and fashion. Questions need to be raised about how this new specialty fares when medical students choose their careers. Anticipatory perceptions and interests, held at the point of entry into medical school, need to be explored. These views and preferences must be monitored as they are exposed to the various socializing influences of the medical school career.

A longitudinal study of medical student career choices, conducted at a midwestern state university, sheds certain suggestive insights into this issue. Although this study is designed to explore the entire range of specialty choices by medical students and to examine the factors underlying the selection of rural or urban practice sites, certain initial findings are specifically applicable to the choice of Family Medicine. Briefly, the design of the study involves the administration of a number of instruments to medical students at the beginning of their first and second years, and then again at the end of their fourth

year (Liccione and McAllister, 1974). Among the instruments used is the Colwill Medical Specialty Perception Inventory, which was administered at the end of the first year and at the end of the fourth year of the students' stay in the medical school. During the third and fourth years, when students moved through a sequence of clinical assignments--the blocks--students were interviewed. Each student was subjected to one interview sequence of two interviews; once before and once after a selected clinical experience. Although, because of limited resources, this sampling only provided one pair of pre- and post-interviews per student, the interviews were arranged in such a fashion that all specialty areas are bracketed by comparable numbers of interview pairs. The first of these interviews seek to tap expectations about the forthcoming clinical experience thus providing information about the student's stance towards whatever encounters and influences may be ahead. The interview conducted after the clinical block seeks to ascertain the implications of the recent experience for the student's choice of specialty, location and style of practice. This methodology is derived from the assumption that the consequences of environment become significant through their interaction with the student's anticipation, definitions, and ongoing processes of choice and self-management.

The data reported in this paper are based on an analysis of the findings from the first of the three classes studied. The suggestive nature of initial findings and their implications for the need to understand the medical school environment gave rise to this paper. From the point of view of the data themselves, they have to be understood as representing early, heuristic results subject to further refinement and

development, particularly after the analysis of the two subsequent classes has been completed.

Before reporting the findings selected for this paper a few words are in order about the medical school in which these data were collected. The administration of this medical school has made a public commitment to stress the education of physicians devoted to primary care, to Family Medicine, and to practice in rural areas. Admission practices, educational philosophy, and a formal statement by the medical faculty are explicitly committed to rural and to primary care and to support the school's program in Family Medicine.

For purposes of this paper three questions are asked: Are there characteristics which differentiate students who choose Family Medicine from those who indicate an interest in other medical careers? Do such choices expressed at the outset of the medical school experience have significance for later decisions? What happens to first year career preferences as students progress through medical school?

(Table 1 here)

Table 1 shows the anticipated career choices of forty-two first year medical students and their choices four years later at the end of their medical school career. This table includes students who had either in the first year or at the end of the fourth year chosen Family Medicine or specialties other than Family Medicine or Internal Medicine.[1] According to Table 1, 26 of these 42 students reported

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[1]Students who had indicated a choice of Internal Medicine either during the first year or in the fourth year are omitted from this table, since early analyses suggested that there might be ambiguity about the meaning of Internal Medicine, thus diminishing the sharp distinctions which are being tested.

TABLE 1

SPECIALTY CHOICES OF MEDICAL STUDENTS
AT YEAR 1 AND YEAR 4

Choice at Year 4	Choice at Year 1		Total at Year 4
	Family Medicine	Other Specialties	
Family Medicine	13	4*	17
Other Specialties	13	12	25
Total at Year 1	26	16	42

*Because there are so few cases in this cell, it is not included in subsequent analyses.

preference for Family Medicine at the beginning of their first year in medical school. Of these 26, one-half (13) continued this commitment and chose to pursue a career in Family Medicine at the end of the fourth year. Of the 16 students who had indicated career choices in other specialties at the beginning of their first year, 12 actually did so, while only 4, after four years, changed their mind towards a career in Family Medicine. The subsequent tables contain no statistical analyses with regard to these four students since their number is too small for statistical treatment. The direction of data, however, will be indicated in the text when appropriate.

Table 1 raises several questions. It is clear from these data that recruitment into Family Medicine seems to be linked to a proclivity in this direction based on pre-medical school interests and orientations. If this pattern is borne out by further research, recruitment into Family Medicine calls for a focus on pre-medical populations. Table 1 further suggests questions about possible differences between those who move from an early interest in Family Medicine to other medical career choices and those who persist in a Family Medicine career. Are these two populations different? Possibly of most consequence are questions to be raised about the factors which seem to move medical student orientation from Family Medicine to other specialties.

In order to examine selected characteristics of these students this paper utilizes data based on the Colwill Medical Specialty Perception Instrument (Cullison, Reid and Colwill, 1976). This instrument involves a battery of 21 statements which the respondent is asked to judge on a five-point scale with regard to him or herself and also as applied to a number of medical specialties. The scale applied to

oneself is always administered at a time different from the day when data are gathered on the perceptions of medical specialties. The sensitivity of this instrument has been described by Edward Brent (1977).

A factor analysis of these perceptions was performed to determine the underlying constructs measured by these variables (Harman, 1960). The factor analysis of the Colwill Medical Specialty Perception Instrument produced five factors accounting for 61.8% of the variance. These factors in order of decreasing variance explained are 1) care, including characteristics such as compassion, humility and personal warmth; 2) science, including characteristics such as intelligence, ability to conceptualize, and desire for intellectual challenge; 3) cure, including characteristics such as satisfaction from working with acute emergencies; 4) status, including both desire for income above the average M.D. and desire for prestige in the community; and 5) outside interests, including the single item, interests outside of medicine (Brent, 1977:5).

In examining whether the data shed any light on the changes in specialty choices from year one to year four as reported in Table 1, the data on self-perception were examined as were the data showing the perception of Family Medicine by these four groups. As other studies (Mauksch, 1960) have reported, data on self-perception tend to be more stable than data describing perception of professional roles. Thus, examining the data on self for the four groups identified in Table 1 revealed no noticeable changes for four of the five factors during the medical school years. On the other hand, the factor "care" produced suggestive findings.

(Table 2, Figure 1 here)

TABLE 2

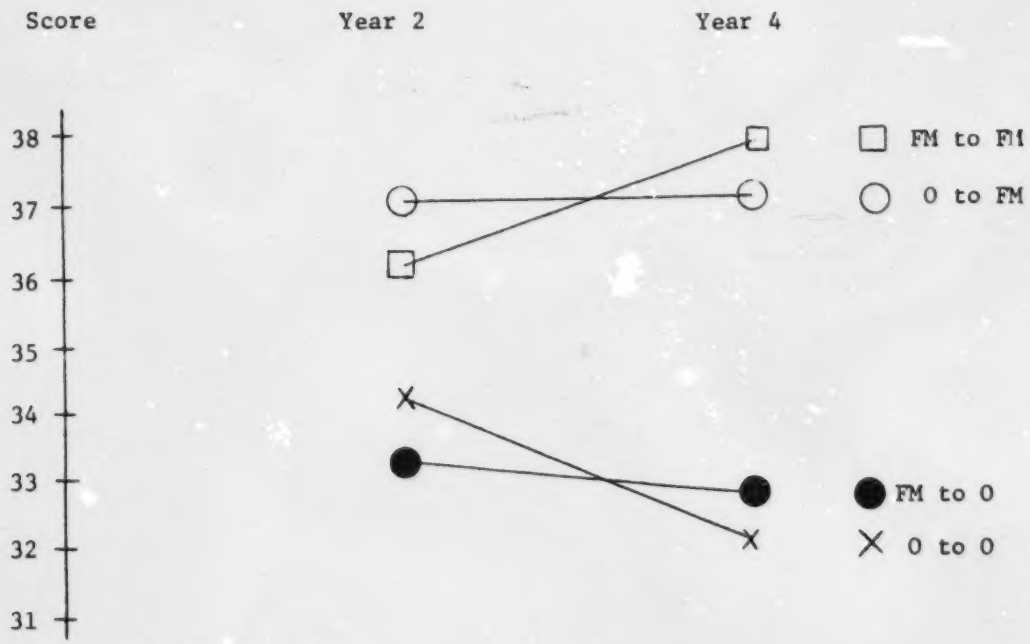
SELF-PERCEPTIONS ON THE FACTOR OF CARE
AT YEARS 2 AND 4 BY CHOICE OF MEDICAL SPECIALTY

		Year 2	Year 4
$FP\text{-}FP_2$[a]	$\bar{X}$	36.05	37.86
	N	13	16
	S	3.99	3.83
$FP\text{-}O_2$	$\bar{X}$	33.30	32.86
	N	13	13
	S	4.61	3.35
$O\text{-}FP_2$	$\bar{X}$	37.06	37.14
	N	4	4
	S	3.14	5.59
$O\text{-}O_2$	$\bar{X}$	34.10	32.15
	N	11	12
	S	6.58	5.99

[a]Notation defined in text.

Figure 1

PERCEPTION OF SELF (FACTOR CARE ONLY)
AT YEAR 2 AND YEAR 4 BY FOUR CAREER GROUPS



The mean score for "care", already at year two separates those who end up in Family Medicine from those who will three years later choose other specialties. Table 2 and Figure 1 show this finding which presages final choices rather than, as one might expect, reflecting the preferences held at the time data were gathered. The difference between the scores of those who stayed in Family Medicine and those who shifted from initially preferring Family Medicine to another medical specialty was not significant at year two ($t(24) = 1.56$) but was significant by year four ($t(27) = 3.57$, $p<.005$, 1-tailed). Figure 1 shows graphically the findings supported in Table 2. It is clear that notwithstanding the small numbers the suggestion of a potentially significant pattern is revealed. The final choice at the end of the medical school career seems to determine the grouping of the four pairs of scores on the factor care. The potential importance of this factor as having predictive significance is suggested not only by the differences between the scores but also by their direction. Choosing other specialties seems to lower those perceptions of oneself which comprise the factor care, particularly for those who had already initially eschewed Family Medicine. By contrast, the score on care increases for those who end up choosing Family Medicine, particularly among those for whom this was a choice throughout medical school. For the purpose of this paper these findings only raise questions. Answers will have to await the analysis of a larger body of data and the testing of these findings in other settings and with other medical student populations.

(Table 3, Figure 2 here)

In Table 3 and Figure 2 attention turns to the mean perception score of Family Medicine. Table 3A reports the perception of those

TABLE 3

A. PERCEPTIONS OF FAMILY MEDICINE AT YEAR 2 AND YEAR 4 BY STUDENTS MAINTAINING A COMMITMENT TO FAMILY MEDICINE THROUGHOUT MEDICAL SCHOOL

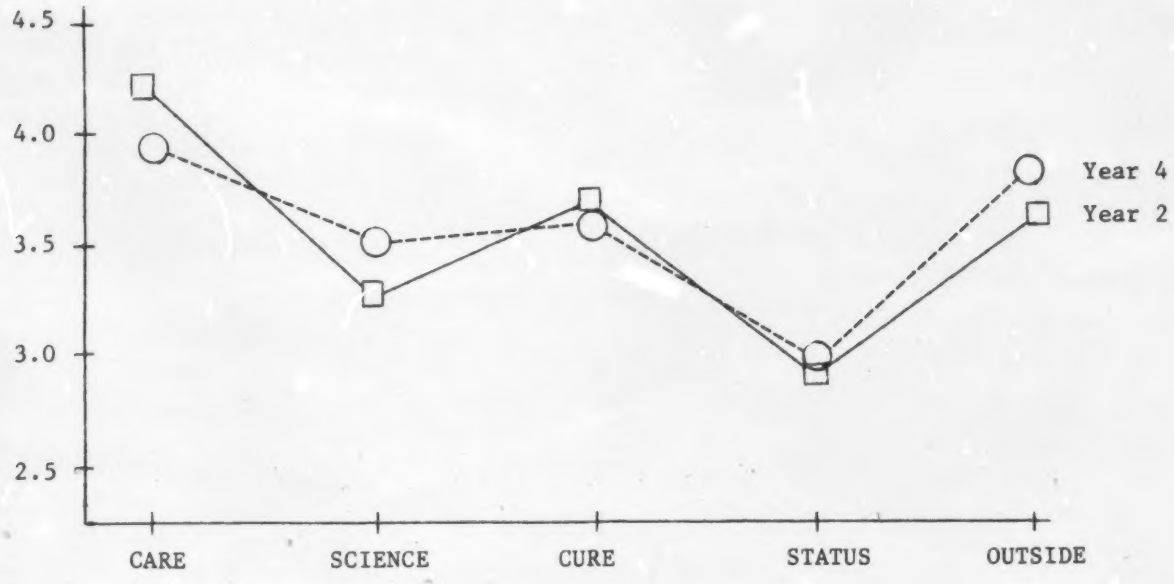
	Factor				
	Care	Science	Cure	Status	Outside
Year Two $\bar{X}$	42.35	32.97	37.23	29.23	36.64
S	5.52	3.28	4.70	4.95	6.67
Year Four $\bar{X}$	39.91	35.31	36.41	29.69	38.75
S	2.53	4.46	4.18	7.18	6.19
t	1.56	-1.63	.50	-.203	-.894
df	30	30	30	30	30
p	NS	NS	NS	NS	NS

B. PERCEPTIONS OF FAMILY MEDICINE AT YEAR 2 AND YEAR 4 BY STUDENTS CHOOSING SPECIALTIES OTHER THAN FAMILY MEDICINE THROUGHOUT MEDICAL SCHOOL

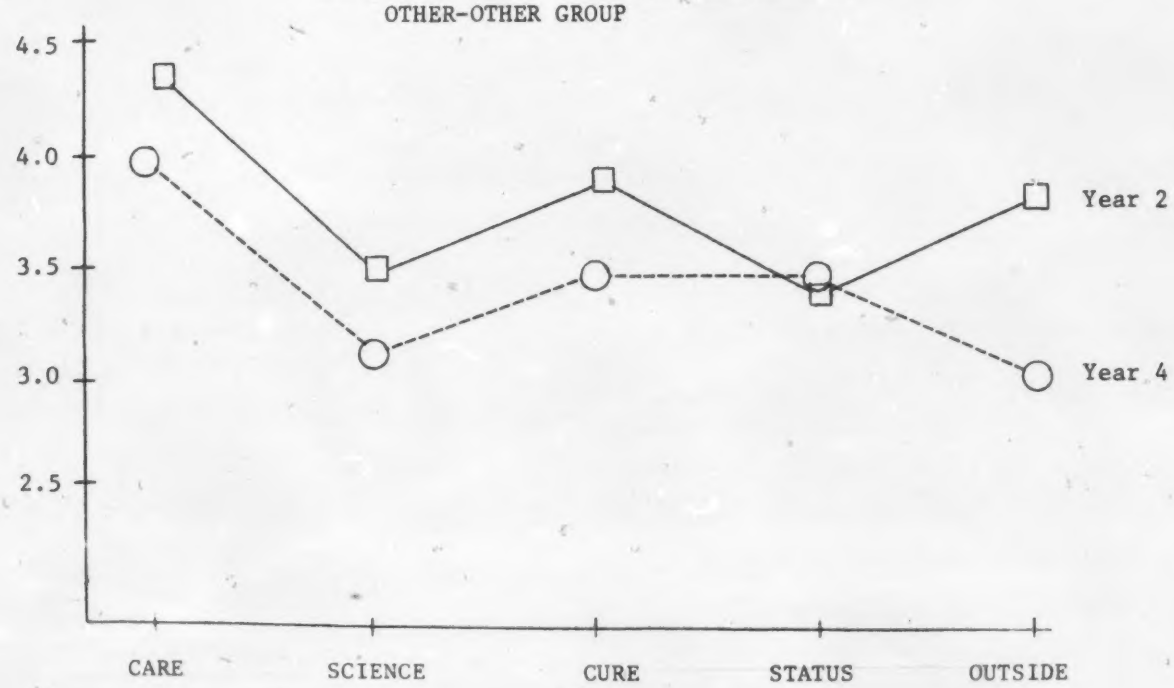
	Factor				
	Care	Science	Cure	Status	Outside
Year Two $\bar{X}$	43.33	34.65	38.70	33.82	38.05
S	4.41	5.99	3.64	7.07	9.37
Year Four $\bar{X}$	39.52	30.83	34.58	34.17	30.00
S	3.18	6.25	5.20	6.34	9.53
t	2.32	1.46	2.16	-.12	2.00
df	22	22	22	22	22
p	$p<.05$	NS	$p<.05$	NS	$p<.05$

Figure 2

A. PERCEPTIONS OF FAMILY MEDICINE BY
FAMILY MEDICINE-FAMILY MEDICINE GROUP



B. PERCEPTIONS OF FAMILY MEDICINE BY
OTHER-OTHER GROUP



students who chose Family Medicine at their second as well as at their fourth year. Table 3B contains comparable data for students whose choice was other specialties throughout their medical school experience. For those students who maintained their choice of Family Medicine, the findings indicate that there are no significant changes in their perception of Family Medicine. On the other hand, there are significant changes in three of the five factors in the perception of Family Medicine by students choosing other specialties. The latter students, in their fourth year, perceived Family Medicine to be lower on care, cure, and outside interests. Although not significant, the score for science also dropped. Likewise, for those students who switched from Family Medicine to other specialties, the scores for care, science, cure and outside interests dropped, although not enough to yield statistical significance.

In the study quoted above, Edward Brent (1977) demonstrated that each of these factors is positively valued by medical students. Hence, these declining scores indicate that, during their exposure to the medical school socialization, students ultimately choosing other specialties developed progressively less favorable perceptions of Family Medicine. These findings add to the argument for the need of a better understanding of the medical school as a factor influencing career choices.

(Table 4, Figure 3 here)

The next data examined explore the changes which take place in the perception of Family Medicine by medical students, particularly by those who switched from Family Medicine to another specialty during the course of their medical school training. Table 4 and Figure 3 report

TABLE 4

A. YEAR 2 PERCEPTIONS

		Factor				
		Care	Science	Cure	Status	Outside
Students Always Choosing Family Medicine (FM-FM)	$\bar{X}$	42.35	32.97	37.23	29.23	36.64
	S	5.52	3.28	4.70	4.95	6.67
	N	16	16	16	16	16
Students Switching From Family Medicine to Other Specialties (FM-O)	$\bar{X}$	43.08	32.31	35.38	29.23	33.85
	S	4.08	6.96	7.06	7.32	10.44
	N	13	13	13	13	13
Students Always Choosing Other Specialties (O-O)	$\bar{X}$	43.33	34.65	38.70	33.82	38.05
	S	4.41	5.99	3.64	7.07	9.37
	N	12	12	12	12	12
Results of Two-Sample t-Tests Comparing (FM-FM) and (FM-O)	t	-.38	.33	.81	.00	.84
	df	27	27	27	27	27
	p	NS	NS	NS	NS	NS
Results of Two-Sample t-Tests Comparing (FM-O) and (O-O)	t	-.39	-.86	-1.40	-1.52	-1.01
	df	23	23	23	23	23
	p	NS	NS	NS	NS	NS

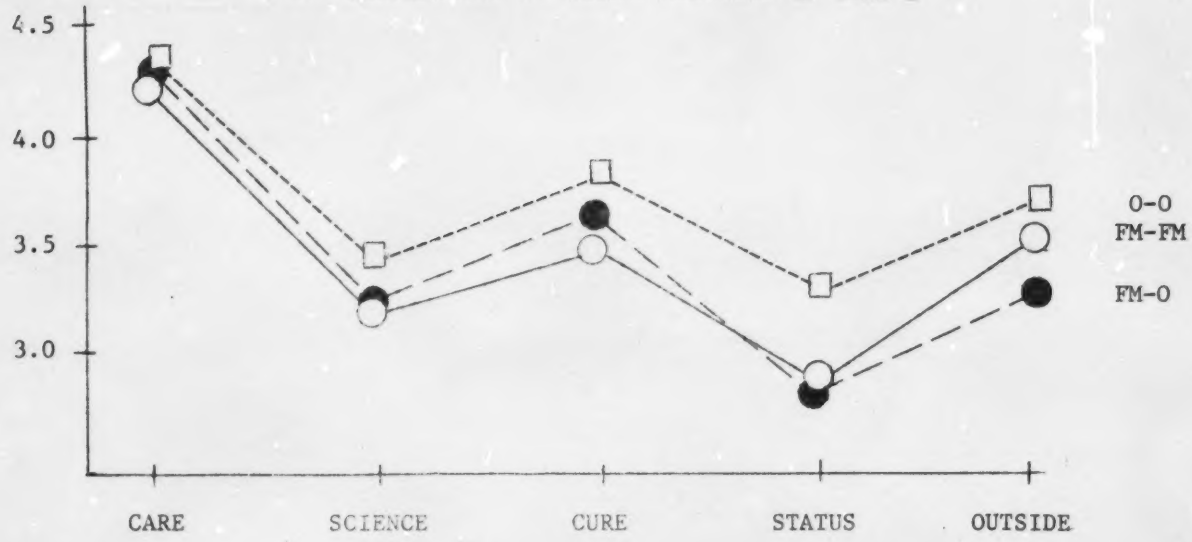
TABLE 4 (continued)

B. YEAR 4 PERCEPTIONS

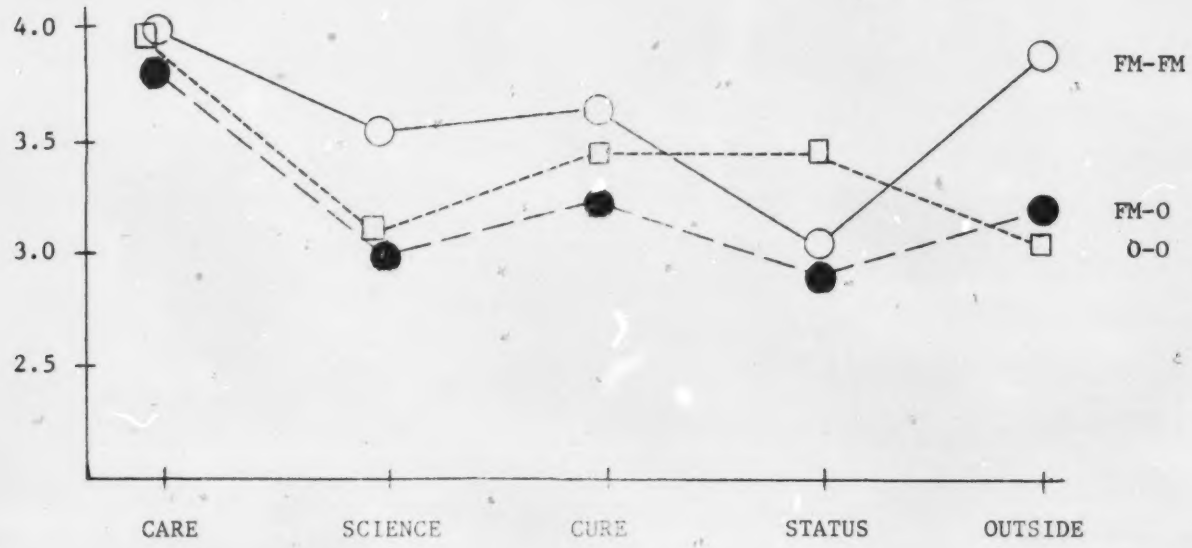
		Factor				
		Care	Science	Cure	Status	Outside
Students Always Choosing Family Medicine (FM-FM)	$\bar{X}$	39.91	35.31	36.41	29.69	38.75
	S	2.53	4.46	4.18	7.18	6.19
	N	16	16	16	16	16
Students Switching From Family Medicine to Other Specialties (FM-O)	$\bar{X}$	38.35	29.81	32.69	28.85	31.54
	S	3.63	8.19	4.50	7.68	9.87
	N	13	13	13	13	13
Students Always Choosing Other Specialties (O-O)	$\bar{X}$	39.52	30.83	34.58	34.17	30.00
	S	3.18	6.25	5.20	6.34	9.53
	N	12	12	12	12	12
Results of Two-Sample t-Tests Comparing (FM-FM) and (FM-O)	t	1.31	2.22	2.23	0.29	2.31
	df	27	27	27	27	27
	p	NS	$p<.05$	$p<.05$	NS	$p<.05$
Results of Two-Sample t-Tests Comparing (FM-O) and (O-O)	t	-0.82	-1.02	-0.94	-1.80	0.38
	df	23	23	23	23	23
	p	NS	NS	NS	NS	NS

Figure 3

A. PERCEPTIONS OF FAMILY MEDICINE AT YEAR 2



B. PERCEPTIONS OF FAMILY MEDICINE AT YEAR 4



mean perceptions of Family Medicine at year two and year four. These data permit comparison of these perceptions for students switching from Family Medicine to another specialty with those of students consistent in their choice either of Family Medicine or of another specialty. These results indicate that students who switch from Family Medicine to another specialty initially perceive Family Medicine in much the same way as students who consistently choose Family Medicine. However, by the end of four years of medical school, this group of students who have abandoned their early choice of Family Medicine appear to perceive Family Medicine in the generally more negative fashion associated with students who have chosen other specialties throughout their medical school sojourn. It appears that those students who initially chose Family Medicine but who opted for another specialty during their medical school training tend to take on views of Family Medicine similar to students who have always chosen other specialties; as time progresses they adopt views in which Family Medicine is seen less favorably.

As mentioned earlier, only four students represent the option of starting out with a choice of one of the specialties and switching to Family Medicine by the end of the fourth year. Although omitted from the tables and figures because of their small number, their scores at the end of the second year resemble those who consistently chose other specialties; however, at the end of the fourth year, they approximate the pattern of those who consistently chose Family Medicine. When looking at Table 4 and Figure 3 one can observe that for all students the scores for care drop from the second to the fourth year. The same can be said for the scores for cure even though for this factor those who choose Family Medicine at the end of the fourth year perceive Family

Medicine higher in the factor cure than the other two groups. The scores for factor "science" begs for further study with the data suggesting that at year four those who choose Family Medicine have noticeably increased their perception of the science component in Family Medicine while the two groups finally opting for other specialties associate less science with Family Medicine than they did three years earlier.

An examination of these data sets the stage for raising questions about the medical school experience and the recruitment and training of future family physicians. If borne out by further data, it appears that the basis for feeding the Family Medicine labor force depends on the recruitment of medical students who have already an interest in Family Medicine. Furthermore, the success of this recruitment process seems linked to self-defining qualities of medical students which may permit prediction of the persistence of early choices. The data reported here suggest that such a differentiating variable might be associated with a personal commitment to a "caring" orientation. It may be even more important to gain a better understanding of the factors which appear to make the medical school experience an environment which moves students away from choosing Family Medicine.

The medical students who were subjects of the study were interviewed twice during their clinical years, once before and once after a selected clinical block. These interviews yield a picture of values, pressures, rewards, and sanctions which suggest an environment in which the choice of Family Medicine can only be interpreted as a process of resistance against the dominant school culture. This statement is made notwithstanding the above reported fact, that the official school

policy had expressed itself as being in full support of primary care and Family Medicine.

It is important for those committed to Family Medicine to examine the assumption that the medical school is a biased socializing environment and that its encounters and experiences mitigate against choosing Family Medicine as a career. It is equally important to acknowledge that this condition, if verified, does not suggest a conspiracy but rather a result of the very nature of the structure of modern medicine, its successes and its impact on the social organization on the delivery of acute care. The structure and process of the medical curriculum reflect to a greater degree than medical educators have generally acknowledged, the peculiarities of the university medical center which is, in most instances, an institution dedicated to tertiary medical care.

The very successes in science and in technology achieved by modern medicine are deeply rooted in the social structure of the university medical environment. The dramatic accomplishments, the breakthroughs in diagnosis and in therapy have resulted in an evergrowing array of subspecialization and the emergence of dependence on an evergrowing number of specialized functionaries within medicine or from newly developed specialty occupations. Relatively little attention has been paid in the literature to the consequence of this network of consulting subspecialties and technological instrumentation. While these achievements have enhanced the system's capability to diagnose and to treat, they have created an environment which tends to diminish the experience of rewarding personal accountability and responsibility on the part of the physician.

As a corollary to the continuing myth of individualized medical practice looms the evidence of the emergence of a network of interdependence, diminishing individual responsibility, and the spreading of responsibility from one practitioner to a network of medical functionaries and to complex units of hardware. In a profound and possibly shocking sense, the socialization of the physician in the modern medical school may reflect a shift towards the development of a highly skilled and powerful technologist at the expense of the socialization of a professional practitioner in the traditional sense of professional practice which, at least as reflected in past literature, has been synonymous with personal responsibility for professional behavior and personal accountability for client welfare (Goode, 1960).

If indeed the organizational reality of medical care and medical education reflects subspecialization and technological dependence, Family Medicine may represent structurally and symbolically a discordant note in the overall theme. Family Medicine may indeed be a reaction to these subspecializing forces and may represent an attempt by some physicians to redefine and recapture an integrative role in the monitoring of health processes. If Family Medicine represents a reaffirmation of personal and professional accountability, then it is not surprising that the real experiences as the student passes through medical school make Family Medicine a less attractive choice by virtue of the nature of the medical role as observed and experienced during the third and fourth years.

This integrative stance taken by Family Medicine flies in the face of another fundamental component of American professional value structure. Modern Western society, particularly American society, is

steeped in a tradition in which status and rewards are positively associated with degrees of specialization and with the precision by which boundaries of competence can be defined and defended. To "know more and more about less and less" is prestigious, and professional status seems to be negatively correlated with the size of the territory claimed as professional turf. Subspecialization also seems associated with complex requirements of formal training and demonstration of competence. Within this setting subspecialties, no matter how esoteric or infrequently called upon, are more likely to receive rewards and recognition than a field which by the very nature of its claims synthesizes rather than reduces, integrates rather than subdivides, and which chooses comprehensiveness and continuity as its criterion of expertise. Neither of these two dimensions can be defined easily by either territory or technology.

In an environment made up of a competitive and sometimes reluctant federation of medical subspecialists, Family Medicine can be expected to appear as a second class choice to students. The empowering flavor of subspecialty qualifications is reflected in Lewy's (1977) account of general practitioners' reference to "those only trained in Family Medicine as 'medical eunuchs'". The low status of the generalist is reflected in the study by Matteson and Smith (1977) which showed that medical students rank Family Medicine low in status within the medical profession.

(Tables 5 and 6 here)

Supporters of Family Medicine are frequently motivated by their concern with the need for physicians who are willing to practice in rural areas. One can observe a prevailing notion that a choice of

TABLE 5

URBAN/RURAL ORIGIN BY FAMILY/OTHER CHOICE

	F →F	F →O	O →F	O →O	Total
Urban	8	4	4	8	
Rural	7	8	0	4	
	n=15	n=12	n=4	n=12	

TABLE 6

URBAN/RURAL CHOICE BY FAMILY/OTHER CHOICE

	F →F	F →O	O →F	O →O	Total
Urban	10	9	1	8	
Rural	6	4	3	4	
	n=16	n=13	n=4	n=12	

Family Medicine is tantamount to a proclivity to select a rural practice site. Tables 5 and 6 show that by and large the tendency towards rural practice by those who choose Family Medicine results in only minor differences. What is interesting in these two tables is that the distribution of rural and urban origin and choices are consistent for both groups whose original specialty preference remained the same at the end of four years. Those who moved from an early choice of Family Medicine to opting for other specialties at the end of their medical education show a shift from rural origin to a choice of urban practice settings. Conversely the small number of medical students who moved to Family Medicine from initial preferences for other specialties appear to reflect a move from urban origin to a preference for rural practice. Here again the reporting of these initial data is only heuristic and suggestive because of the small numbers.

There is, however, another way in which the description of the social and professional world of the medical center is likely to influence the site of practice. Early in this paper it was suggested that specialization and division of labor with its ensuing fabric of functional interdependence and occupational heterogeneity characterizes the medical center. The medical practice setting is characterized by density of population and territorial boundaries. All of these characteristics of the modern medical center suggest the traditional definition of urbanism (Wirth, 1938). The medical school is indeed an urban institution and it rewards accommodation to urban ways of life. The medical center as it embraces the future physician rewards those medical students who fit well into a network of practice composed of a plethora of different specialties within medicine and involving a large number of

other occupations; it rewards behavior which accommodates and conforms to the highly specialized performance of specified detailed tasks which result in a sequence of almost anonymously assembled processes. It rewards the learning of skills which enable the future physician to select data from a variety of laboratories and technologies and to translate them into diagnostic or therapeutic activities. In other words, within the framework of the current medical center, the future physician learns that quality of medical care is highly associated with the dependence on a large number of specialized skills, types of equipment, professional specialties and the ability of collecting data from various sources as a prelude to medical decision-making.

Using the term socialization in describing the medical school experience implies that the encounters and events of these four years will not only teach content but will also formulate habits, expectations and a sense of comfort or discomfort in various professional settings. If the close proximity and dependence on resource personnel and technology becomes an index of security and quality, a choice of an urban practice setting and of a clearly defined specialty is more likely in the offing.

Thus far this paper has examined the medical school environment in terms of its structural and professional aspects. The curriculum itself provides not only subject matter, content, and practice experience but it also signals the real rather than the professed priorities of the system. As Becker et al. (1961) emphasized in their class study, medical students, like all occupants of high pressure environments, learn early to distinguish between the language and the reality of the powers which control their fates. In most medical curricula the

structure of the first two years emphasizes the primacy of the laboratory sciences and sets the stage for the prestige and reward structure of subspecialty competence. Courses devoted to "being a physician", whether couched as learning about taking histories, interviewing, or other aspects of the physician-patient contact, are generally of low prestige and considered the soft part of the first two years. In those few medical schools in which the behavioral sciences make an appearance in the first two years of the medical curriculum, they are rarely valued, taken seriously or perceived to represent a valid scientific or professional basis for the practice of medicine. What implication does this value pattern have for a specialty which claims comprehensiveness of the patient experience as one axis of expertise?

The third and fourth year of the traditional medical school curriculum represents a different scenario. Typically, it is structured as a sequence of assignments to departmental domains, control systems and spheres of influence through which students pass on their way through required and elective territories. The clinical years belie the notion of a consistent integrated theme which governs the educational processes of becoming a physician. On the contrary, the quasi-proprietary order and the ethnocentrism and evangelism of various subfields of medicine make the student appear in some ways like a potential customer moving from sales exhibit to sales exhibit rather than as a future professional who, at all times, is enveloped in a climate of inquiry, relativity of knowledge, and invitations to raise new questions and to show intellectual skepticism.

The structure of the curriculum during the clinical years gives the impression of a topography with terrain features which range from

those clearly visible and marked, to some which are barely identifiable. The traditional major specialties in medicine are clearly visible landmarks through which the student must pass as he travels through the curriculum. As Goode (1957:196) observed, most professional programs "almost isolate their recruits from important lay contacts (and) furnish new ego ideals and reference groups..." Some career options in medicine appear as optional places to visit during the third and fourth year while others are either not available, or require special arrangements. Family Medicine, a relatively recent arrival on the specialty scene, appears in different ways in different medical schools. Only rarely, however, is it a regular required experience for all students. Lacking the structural reality of claimed time and space constitutes a message as far as student experience and student perceptions are concerned. As long as allocation of student time in the third and fourth year curriculum reflects prestige and power among medical specialties, Family Medicine will not fare competitively in its bid for student choices.

Many of the observations offered in this paper have in one form or another been made by medical educators or researchers as part of a variety of commentaries about medical education. Thus, as these themes emerge from interviews they blend quickly into observations and data previously acquired by the authors. One finding, however, emerged which has not been addressed in the literature. The peculiar, powerful role of interns and residents in the education of medical students within a medical center appears to be so crucial in the process of career choice that it seems surprising that not more attention has been paid to this issue.

The problematic and ambiguous structural position of the house staff has been studied (Miller, 1970; Mumford, 1970) primarily as it affects their own career in the profession and as it influences patient care. While the period of residency is considered primarily to be a vehicle for postgraduate education, it is generally acknowledged that the house staff provides the bulk of medical practice in a large teaching hospital. The reports of the students interviewed testify to the fact that by far the largest amount of educational contact with practicing physicians occurred with house staff rather than with the faculty. It is from house staff that students report to have received not only educational content but also the climate and the culture of their block. The interviews suggest that the recruitment process into specialties emanates frequently from the interns and the residents rather than from the attending physician.

This insertion of interns and residents into the organizational structure and educational experience of the medical student has important consequences which are linked to the ambiguous social status of the house staff itself. They represent a classical example of a social category which, although placed into an acknowledged niche, remains to a degree structurally segregated from the institution in which they function, in some ways reminiscent of the classical description of the stranger (Simmel, 1952). As members of the house staff, interns and residents have loyalty to their specialty and to their department but are neither structurally, nor socio-psychologically committed to the policies and philosophies evolved by the faculty and administration of the school of medicine. Thus, in a school of medicine in which academic administration and faculty assemblies have made a commitment to

Family Medicine, this commitment and its underlying philosophy has no meaningful provisions for being transmitted to the house staff whose teaching roles are only minimally formalized, although shown to be a major educational reality. Values of their respective department rather than the policies of the school will mingle with the orientations imported from their own respective educational environments. Yet interns and residents serve as possibly one of the most influential shaping forces in the career choices and socialization experiences of future physicians.

In this paper the point is made that the modern, complex medical center is not a favorable environment in which to develop a career commitment to the practice of Family Medicine. It has also been suggested that the apparent relative success of bringing new cohorts of young physicians into Family Medicine may be related to early, pre-medical school choices and that those who move into Family Medicine are the survivors of a larger early body of students oriented toward this version of primary care. The data reported in this paper report the tentative findings that those whose commitment to Family Medicine persists may bring a certain perception of themselves as "caring" professionals into the specializing environment of the medical center. The main thrust of this paper, however, is to emphasize that the specialty-favoring, urbanizing climate of the medical school is deeply embedded in the very nature of current medical science, its technology and the social structure of patient care delivery.

With all of the successes which Family Medicine has achieved since its inception it is still considered a problematic entity among medical specialties. Among the choices which this body of medical practitioners

is forced to make are those which affect the recruitment of students into this specialty. This question may, however, be not merely one of assuring numbers. A more important issue, as suggested in this paper, may be the kind of novice who is attracted to Family Medicine as its image, its message and its reality may undergo changes. One could oversimplify the implications of this paper as suggesting that those attributes of Family Medicine which currently seem to attract recruits are the very ones which account for this specialty's low status and influence. Acquiring the claims to traditional academic medical respectability may gain territory for Family Medicine at the expense of attracting those to whom Family Medicine represents, at this time, the way of being a physician. The question to be addressed in the future involves the issue of the quality and characteristics of students attracted or lost as Family Medicine maintains or alters its image and structure.

Family Medicine seems confronted on one hand by the academic values of medical laboratory science, demonstrable territorial and functional claims, and control over unique technologies. On the other hand, Family Medicine symbolizes comprehensive primary care with romantic overtones of a return to the good old days of the personal physician. While there is reality to this dichotomy, a third model with its own opportunities and dangers can be identified in the dialogue governing the future of Family Medicine.

If the name of the specialty and the justifications given for its emergence are taken literally, Family Medicine can be seen as the specialty which translates the comprehensive experience of illness and the striving for health into a systematic body of expertise using the context of family life as the basis for research and practice. If the

links between family process, personal existence, and organismic functions become the basis of scientific expertise (Mauksch, 1974) Family Medicine can claim a territory, a domain of research and a field of preeminent practice. At the same time this field of competence is based on the human service demands and takes its justification from the needs for personal care and continuity. Thus, it would seem that Family Medicine could simultaneously capture academic respectability and symbolic appeal. Yet this option, as appealing as it may be, forces Family Medicine far afield from the traditional primary reliance on the biological and physical sciences and forces a link of Family Medicine with the social sciences which, at best, are suspect and untested as a scientific basis for the practice of medicine. Regardless of its scientific and philosophic merit, the politics of embracing the social sciences are risky. The full development of this model may involve early struggles but may, in the long run, provide Family Medicine a defined place in the sun and a significant contribution to the health care needs of our society.

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